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ABSTRACT

This report explores ways to implement ideas outlined by the Council of Chief State School Officers (CCSSO) in a November 1992 policy statement. The CCSSO statement called for joint action by state and local agencies to prepare students for productive employment, healthful lifestyles, knowledgeable and contributing citizenship, strong family formation, and other adult responsibilities. This report maintains that these goals cannot be achieved without a major overhaul of children and family services at the state and local level to make these services comprehensive and fully integrated. Any comprehensive system must focus on: (1) a structure of service integration; (2) a joint-enterprise type of collaboration among professionals and families; (3) a universal, neighborhood-based approach to service provision; (4) a holistic, family-centered, and multi-generational strategy; and (5) an enabling, responsive, and outcome-accountable management style. Two appendixes discuss the funding of various human services agencies and facts about children in poverty. (MDM)

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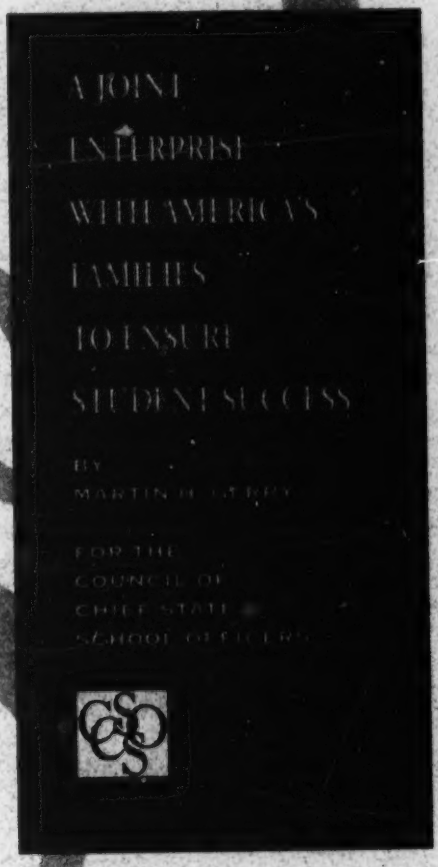


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# A Joint Enterprise with America's Families to Ensure Student Success

*Martin H. Gerry, J.D.*

# COUNCIL OF CHIEF STATE SCHOOL OFFICERS (CCSSO)

The Council of Chief State School Officers (CCSSO) is a nationwide non-profit organization of the 57 public officials who head departments of public education in the 50 states, five U.S. extra-state jurisdictions, the District of Columbia, and the Department of Defense Dependents Schools. It has functioned as an independent national council since 1927 and has maintained a Washington office since 1948. CCSSO seeks its members' consensus on major education issues and expresses their views to civic and professional organizations, to federal agencies, to Congress, and to the public. Through its structure of committees and task forces, the Council responds to a broad range of concerns about education and provides leadership on major education issues.

Because the Council represents each state's chief education administrator, it has access to the educational and governmental establishment in each state and to the national influence that accompanies this unique position. CCSSO forms coalitions with many other education organizations and is able to provide leadership for a variety of policy concerns that affect elementary and secondary education. Thus, CCSSO members are able to act cooperatively on matters vital to the education of America's young people.

The CCSSO Resource Center on Educational Equity provides services designed to achieve equity and high quality education for minorities, women and girls, and for the disabled, limited English proficient, and low-income students. The Center is responsible for managing and staffing a variety of CCSSO leadership initiatives to assure education success for all children and youth, especially those placed at risk of school failure.

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# Executive Summary

In November 1992, the Council of Chief State School Officers adopted a major policy statement calling for joint action by appropriate state and local agencies to prepare students for productive employment, healthful lifestyles, knowledgeable and contributing citizenship, strong family formation, and other adult responsibilities.

In this monograph, *A Joint Enterprise With America's Families to Ensure Student Success*, Martin Gerry poses three questions in order to further explore the Council's call for collaborative action to ensure student success:

- What should be the parameters of a comprehensive collaborative effort to ensure student success?
- Can the goals of such a comprehensive collaborative effort be achieved within the current structure of education and human services?
- If not, what are the key characteristics of a new comprehensive collaborative system?

Analyzing the often dismal outcomes of our present attempts to support children and families, Gerry concludes that the goals sought by the November 1992 policy statement simply cannot be achieved without a major system reform. A new vision of a comprehensive collaborative system of children's and family services and supports is needed. In designing a system that will prove effective in meeting the complex needs of children living in multiproblem families, Gerry warns that we will find no perfect models or even paradigms. Experience, however, strongly argues that any comprehensive system of child and family services be designed to incorporate each of five basic characteristics:

1. *A structure of services integration*—While service integration will not itself eliminate all the shortcomings of the current situation, it is an important precondition for removing both structural and administrative barriers that ultimately frustrate any effort by families to obtain the combination of services and supports they need to solve serious and pervasive economic and social problems.

2. *A joint-enterprise type of collaboration among professionals and with families*—The concept of a joint enterprise differs from the other more traditional (and less demanding) forms of professional collaboration in one important way. In a joint enterprise, all participating child and family service providers and the family members, themselves, are responsible jointly for the achievement of child-specific and family-specific, unitary, systemic outcome measures. Thus, the success or failure of all of the members of the joint enterprise (including professional and employment rewards and punishments) is based on the collective outcome of teamwork. The joint-enterprise approach also recognizes that collaboration must not only be among professionals but also *with* children and families. Because "personal responsibility" and "family self-sufficiency" are meaningful only when they are accompanied by real choices, a child or family who has neither the opportunity nor choices to act have not had their needs met by the human service system.

3. *A universal (noncategorical) and neighborhood-based approach to service provision*—Most current child and family service and cash benefit programs are categorical in nature precisely because eligibility for, or entitlement to, benefits or services is determined not only by the need for the benefit or service but also by the presence of a particular extrinsic characteristic, often one that is pejorative at best and disempowering at worst (e.g., economically disadvantaged, handicapped, or emotionally disturbed). In addition to the damaging effects of many categorical eligibility standards on the self-concept of, and system expectations for, these "labeled" children and families who are eligible, large numbers of children and families with severe service needs are currently ineligible. Flexible funding approaches at the local level are also needed to cover services that are crucial to goal achievement but not covered under narrow, rigid, categorical service definitions.

4. *A holistic, family-centered and multigenerational service focus*—Experience repeatedly demonstrates the interconnectedness of child and family problems and the interrelationship of economic and social stresses and problems within the family. As a result an essential characteristic of a successful child and family service system for children in multiproblem families is the adoption of a critical mass service approach that demands both a family-centered and multigenerational focus. A critical mass approach assumes that no significant developmental gains of any kind are likely to occur for children living in families with complex needs if a critical mass of services and supports are not available to the entire family.

5. *An enabling, responsive, and outcome-accountable management style*—Any serious effort to improve the lives and prospects of American children must, in turn, support and strengthen their families. This normalization-based strategy requires both that the human and financial resources available within families be expanded, and, in many cases, that family functioning be improved, so that families can take full advantage of a range of social and economic opportunities that are made available. An operational style that is, in practice, responsive to families and children is a closely related, essential characteristic of a comprehensive system of services and supports for children and their families. If a comprehensive system of child and family services is to be simultaneously enabling and responsive, legal, programmatic, and financial responsibility must be explicitly allocated among agencies and across systems; and a single, neighborhood-based professional must be directly accountable to the child and family at all times for both the short-term and long-term outcomes of services and for necessary changes in service design and delivery.

Gerry suggests that three central parameters should guide the comprehensive collaborative enterprise envisioned by CCSSO's November 1992 policy statement. The first is that a common set of outcome goals must be agreed on, and they must cut across the various disciplines and programmatic structures of educational and human services agencies. Second, the test of the merit of such an effort will be its ability to serve well those children in multiproblem families who fare least well under the present structures. And third, a broad notion of who should collaborate is essential, extending not only to public and nonpublicly employed professionals but to family members themselves.

The goal of CCSSO's 1992 policy statement—joint collaborative action by appropriate state and local agencies to ensure that children and youth are adequately prepared for adult responsibilities—is of vital importance not only to American education but to the very economic and social security of this nation. To accomplish what the CCSSO policy statement envisions will require much more than reform or even a "paradigm shift." What is needed is a true transformation of our present structures to a just and humane system of child and family services and supports.

A successful transformation will mean the end of the growing nightmare of serial generations of Americans lost not in battle but to despair and terminal government dependency. Failure will mean the end of the American dream, not only for those now least well off but for the rest of society as well. To try to accomplish this transformation is almost politically unthinkable, but not to try is morally, socially, and economically untenable.

# A Joint Enterprise with America's Families to Ensure Student Success

***Martin H. Gerry, J.D.***

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In November 1992, the Council of Chief State School Officers adopted a major policy statement calling for joint action by appropriate state and local agencies to prepare students for productive employment, healthful lifestyles, knowledgeable and contributing citizenship, strong family formation, and other adult responsibilities. In its 1987 report, *Children At Risk: The Work of the States*, CCSSO took the national lead in urging special attention to the multidimensional problems of children "at-risk" of educational failure. In the companion 1987 policy statement, *Assuring School Success for Students At Risk*, CCSSO outlined 11 specific principles that it believed should govern educational programs for children "at-risk." These documents both repeatedly cite the need for a holistic approach to child and family problems (CCSSO, 1987). As the National Commission on Children (1991, pp. 39-41) has emphasized, and the Council acknowledges, child development is a cumulative process, beginning before birth and continuing into adulthood, which reflects and ultimately depends both on a child's natural endowments and childhood experiences. Development is the process through which children mature physically, socially, emotionally, intellectually, and morally. Because families do not exist in isolation, children's development is shaped by many other influences present in their homes, schools, neighborhoods, and cultures. The reciprocal interactions among these factors, together with a child's own inherited characteristics, determine development. Each stage of child development builds on the achievement of the previous one.

In support of the 1987 policy statement, CCSSO has a number of initiatives underway to assist state educational agencies develop collaborative arrangements with other human service agencies at the state level and promote similar collaboration at the local level (CCSSO, 1993). The answer to three questions will be of central importance to defining the Council's call for joint collaborative action to ensure student success:

1. What should be the parameters of a comprehensive collaborative effort to ensure student success?
2. To what extent can the goals of such a comprehensive collaborative effort be achieved within the current structure of education and human services?
3. If not, what are the key characteristics of a new comprehensive collaborative system?

## BACKGROUND

The genius of the American social and economic system has been its fundamental reliance on the independence, productivity, and social responsibility of its citizens, families, and local communities. American families have traditionally borne the primary responsibility for child development. This responsibility has included meeting their children's most basic developmental needs. Benoit (1991) has described these needs as follows: During the first three years of life, infants and toddlers need an environment that responds fully to their basic physical needs; provides unconditional acceptance and consistent, stable nurturing by a primary caretaker; and includes "well-titrated" stimulation designed to meet physiological, cognitive, tactile, and emotional needs. The physical

needs of all children include proper medical care, appropriate nutrition, nurturing, protection from abuse and neglect, and a general sense of trust in their physical environment(s).

Families' additional responsibilities include teaching fundamental lessons about personal relationships, life skills and moral conduct, and assisting their children develop their capacity to function responsively and creatively as adults in the domains of work, family life, and citizenship (National Commission on Children, 1991).

Although the family has been the fundamental social institution of American society, extended families and an informal network of community institutions, religious organizations, and local associations—autonomous from state control—have played the central role in providing support to the family in times of unusual stress or need when demands overwhelmed the capacities of families. Grandparents, cousins, friends, and neighbors have helped families in crisis cope with the economic hardships and personal tragedies and difficulties of day-to-day life, frequently without any involvement of government.

The first expansion of the traditional social support role of government occurred in the 1930s with the passage of the Social Security Act, which mandated federal administration of new, public, social insurance systems. Within these programs the role of the federal government was seen simply as that of a trustee or fiduciary safeguarding individual insurance accounts. It was not until 30 years later that a truly radical redefinition occurred in the role of both state and federal government in American society. With the enactment of a series of new categorical grant programs, government (both state and federal) sought to intervene directly to solve a broad range of individual social and economic problems, including unemployment, educational disadvantage, inadequate health care, and deteriorating housing.

In contrast to the universal self-protection strategies of the New Deal, the Great Society era (beginning in the early 1960s) spawned over 200 *categorical* federal programs designed to address specific problems experienced by various categories and subcategories of individuals and families. These programs were and are categorical in nature because access to them (i.e., eligibility for benefits or services) is *not* universal (i.e., based only on child or family need) but is conditional on the presence or absence of a particular secondary characteristic of the child or family, such as poverty, disability, age, or some specific disadvantage such as need or homelessness.

Other differences between the governmental programs of the '30s and the '60s include the ways they were financed and the ways the benefits were provided. The New Deal programs of social insurance were financed by earmarked payroll tax contributions of the persons to be benefitted in the same way as private insurance, and thus no stigma was automatically attached to participation. And the New Deal social insurance systems were concerned with income replacement (i.e., cash payments), not the need-based services of the Great Society.

## THE PARAMETERS OF COLLABORATION

The November 1992 CCSSO policy statement on collaboration calls for joint action by education and other human services agencies at the state and local levels to prepare students for productive employment, healthful lifestyles, knowledgeable and contributing citizenship, strong family formation, and other adult responsibilities. If we are to proceed with joint action at the state and local levels, however, we must identify at least three basic parameters of such a comprehensive collaborative effort:

1. A common set of measurable outcome goals for children (students) to be used by all participating education and human services agencies and programs.
2. Those students (i.e., children and youth) who should be the primary targets and beneficiaries of the joint action urged by CCSSO.
3. The agencies and individuals who should form the core of the collaborative effort.

### A Common Outcome Goal for Children

The theologian and ethicist, Reinhold Niebuhr, has identified *justice* as the first moral principle of society and has defined justice, not in the familiar retributive framework of the Old Testament, but rather in terms of social fairness:

> From the perspective of society, the highest moral ideal is justice ... [and]... the highest moral insights and achievements of the individual conscience are both relevant and necessary to the life of society. The most perfect justice cannot be established if the moral imagination of the individual does not seek to comprehend the needs and interests of his fellows. Nor can any non-rational instrument of justice be used without great peril to society, if it is not brought under the control of moral goodwill. Any justice which is only justice soon degenerates into something less than justice (Niebuhr, 1932, p. 257).

The implications of this concept of *justice as fairness* have been explored in depth by John Rawls (1971) and other contemporary social philosophers. Rawls argues that the tenets of justice in the sense of fairness are properly developed by a policymaker in a state of "reflective equilibrium," in which the policymaker would fully understand the dimensions of the overall situation but would not know anything about his or her personal characteristics. Rawls argues further that a rational person in such a position, to be self-protective, would develop a set of social policies that would be seen as "fair" by the least favored individuals in society. Thus, in deciding what outcomes of social policy were fair, the bottom limit on the outcomes for the least advantaged members of the society would in all probability be set at what is perceived as the "normal" outcomes for the more favored members of society.

In direct contrast to the categorical program model that insinuates a pathology-based model on contemporary education and human services structures, a human service philosophy of normalization brings with it a *preventive* health/health maintenance mindset. The difference between these two approaches is profound. In the pathology-based model, the persistence of high rates of long-term family dysfunction and economic and social dependency, while unfortunate, are seen as the inevitable consequences of the underlying pathology of the families, individuals, and even communities. From this standpoint, major negative deviations in social and economic outcomes for children and families are rationalized as due to factors beyond the control of the education and human services program structures. Once these chronically (if not "terminally") ill families have been diagnosed, they become a "case" consigned to "professionals" whose job it is to ensure that they receive just enough support to survive, but not enough to thrive. The pathological warp of this approach reaches almost unbelievable heights when, for example, a family on welfare that sacrifices to save money from its welfare allotment to help finance a child's higher education is threatened with prosecution for welfare fraud because it has acted responsibly and accumulated assets.

In contrast, a normalization-based model would view persistently high rates of long-term family economic and social dependency as indicative of service-system dysfunction. Rather than search for family-based, pathological justifications, such a normalized model would start from a premise that families and individuals can and do identify and resolve most of the social and economic problems that confront them without continuing assistance of government agencies. Where this is not occurring even with short-term, intensive support, a normalization-based approach would focus on identifying the factors within the functioning of the family or in the service and support structures that are preventing normal problem solving. These factors could be situation-specific (e.g., an intense, short-term family domestic crisis), resource-linked (e.g., an unusual drain on family problem-assessment resources, limited family emotional resiliency), or support system-based (e.g., difficulty in obtaining needed information or in identifying realistic options or choices). As a final step, a normalization-focused approach would dictate the development of a time-limited plan to provide the family the needed combination of services and supports to restore healthy family functioning.

Today, unfortunately, the levels of economic and human resources possessed by many American families faced with stressful conditions appear far less adequate than in the past to support effective family self-assessment, informed choice of solutions, and effective remedial action. (Interestingly, American families continue to reach remarkable levels of self-reliance in providing informal home and community-based care for elderly family members who need assistance with daily living.) Large numbers of economically disadvantaged American families appear able to bring to bear smaller and smaller reserves of economic or human resources than ever before. As a result, and without many of the informal neighborhood and community support structures that have been traditionally available, a rapidly growing number of families have come to depend on government for the services and supports they need.

The set of goals shown in Figure 1 presumes that each child should be able to uniquely define the points on each of the five *continua* that he or she reaches. Given such a set of outcome goals, the reform of the current ineffective array of disjointed programs becomes a moral imperative.

## Children in Multiproblem Families

The concept of *justice as fairness* and the philosophy of *normalization* both argue persuasively that the children who should be the primary beneficiaries of the joint action urged by CCSSO are those children faring least well within the current structure. A review of the outcomes of both the education and human services systems over the past three decades conclusively demonstrates that, as a group, children living in multiproblem families have fared least well.

Since 1970, the number of children living in multiproblem families has rapidly increased as the integrity and functioning of significant numbers of American families have eroded. This erosion has occurred as a direct result of the cumulative effects of



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**Figure 1**
**Outcome Goals for Children's Services**

**Each child (and later adult) will have the maximum opportunity:**

- To be physically and emotionally secure and healthy;
- To exercise freely his or her autonomy, creativity, and spirituality;
- To choose his or her areas of independence and interdependence, and degree of social participation;
- To form and maintain caring and loving relationships with others; and
- To live a productive and, to the greatest extent possible, economically self-sufficient life.

a number of negative economic and social trends, including prolonged unemployment and poverty, substantial increases in preventable illness and injury, and rapid escalation in the incidence of substance abuse, crime, and violence.

In addition, the growth of both single-parent households and two-parent, wage-earner families has posed additional difficulties for caregiving. Many middle- and low-income parents, including those in two-parent families, find themselves spending more time away from their children because, in response to economic pressure, many parents are working longer hours. Today, approximately 10.9 million children under age 6, including 1.7 million babies under 1 year and 9.2 million toddlers and preschoolers have mothers in the paid labor force. Over 65 percent of children ages 6-13 had working mothers in 1990. (Between 1970 and 1990, the proportion of mothers with children under age 6 who were working or looking for work outside their homes rose from 32 to 58 percent.) For a rapidly growing number of American children, care by adults outside their immediate family is becoming an increasingly common aspect of everyday life. Nearly 20 million children, about 70 percent of those with employed mothers, are cared for by an adult other than a parent, grandparent or sibling (National Commission on Children, 1991, pp. 22-28).

More than 16 million American children (one in four children in the United States) are currently being raised by just one parent (by comparison, in 1970 only about 12 percent of children lived with only one parent). This parent is usually a divorced or unmarried mother. For whites, the increase in single-parent families is primarily due to divorce and separation; for blacks, it is primarily the result of childbearing outside of marriage. In 1960 only 5 percent of all births in the United States were to unmarried mothers; in 1998, more than 25 percent were. In addition, the steady erosion in the earnings of young men in low-income communities over the last three decades has made it increasingly difficult for many—especially young minority men with limited education and job skills—to earn an income sufficient to support a family. Between the mid-1970s and the mid-1980s, marriage rates among 20- to 24-year old men declined by nearly half—from 39 to 22 percent—compared to only a 3-percent decline during the previous decade (National Commission on Children, 1991, pp. 18-24; U.S. Department of Commerce, 1990a, p. 20; U.S. Department of Commerce, 1990b, p. 3, Table C).

Moreover, approximately 43 percent of mother-only families are poor, compared to only 7 percent of two-parent families (National Commission on Children, 1991, pp. 18-24). Each year, more than half a million babies are born to teenage girls, most of whom are unmarried, many of whom have not completed their education, and few of whom have prospects for an economically secure future (National Commission on Children, p. 4). Births to adolescents are especially likely to occur outside of marriage. Approximately 40 percent of white babies and 90 percent of black babies of teenage mothers are born into single-parent families (National Commission on Children, p. 19).

Children living in single-parent families are more likely to experience persistent poverty than children living in two-parent families. The average income of

mother-headed families is only about 40 percent of the average income of two-parent families at the same age, and the median earnings of young female single parents was $3,005 in 1989 (this represents barely 36 percent of the official poverty level of a family of two and is substantially below the poverty level for a family of three). Nearly 75 percent of all American children growing up in single-parent families experience poverty during their first 10 years, compared with 20 percent of children in two-parent families. Among children living only with their mothers, sustained poverty for 7 or more years is common; among children living with both parents, it is rare (National Commission on Children, 1991, p. 83).

Nearly 13 million American children (1 out of 5 children) live in families with an income below the Federal Poverty Level, and the poverty rate for children under age 6 is even worse. "The 23 percent poverty rate for children under six in 1987 was higher than the rate for any other age-group in the United States" (National Center for Children in Poverty, 1990, p. 18). Nearly 5 million children live in families with incomes less than half the Federal Poverty Level; this represents an increase of approximately 15 percent during the past decade alone (National Center for Children in Poverty, p. 24).

Perhaps most disturbing of all is the increase of nearly 50 percent (between 1975 and 1987) in the number of poor young children living in areas of concentrated poverty, from 1.5 million in 1975 to 2.2 million in 1987 (National Center for Children in Poverty, p. 23). Poverty, single parenthood, mental illness, drug abuse, and social isolation can weaken families and impair some parents' ability to care for their children. When families are in turmoil, children are often the helpless victims of their parents' frustration and despair (National Center for Children in Poverty, p. 281). The resources and resiliency of even the strongest families have been severely strained by these complex economic and social forces.

Several important economic and demographic trends—which have occurred in lock-step with the increase in family dysfunction—have undermined the continued viability of many informal neighborhood and family support structures in urban and rural areas. (For example, the age stratification of urban/rural versus suburban populations has increased, the rate of chronic unemployment has worsened, commercial and residential tax bases have eroded, housing and transportation systems have deteriorated, crime and drug-related violence has increased, and church attendance has declined.) Parents in many of these families often lack the emotional, physical, and material resources to meet their children's basic developmental needs as a result of chronic poverty, stress and disorganization. Because the parents of the children are typically young, unmarried, and economically disadvantaged, they lack the knowledge, skills, and emotional energy to provide the consistent care and attention, structure, and learning experiences that prepare children for school and life. Many children in these families experience failure from the earliest stages of life and come to believe they are meant to fail. Without some positive intervention, they frequently reach adolescence perceiving that the future holds little possibility for them and, thus, that they have little to lose by dropping out of school, using drugs, committing violent crimes, or having babies at a young age (National Commission on Children, pp. 27-28, 36-37). To many children and families who experience a combination of these problems, or who face them for extended periods of time, they often appear insurmountable. As Lee Schorr (1988) has observed, in families experiencing severe stress, love often turns into neglect, affection into hostility, and discipline becomes abuse.

## Who Needs to Collaborate?

Little real collaboration among human service providers and professionals currently exists in the United States primarily because of the categorical mentality of most federal and state human service financing systems and the comparative scarcity of public human services resources. Current systematic disincentives to human service collaboration include conflicting eligibility requirements, rigid funding mechanisms, "turf protection" by program-specific bureaucracies, and highly specialized professionals who tend to focus on the isolated problems they are trained and credentialed to address rather than on the interrelated needs of children and families (National Commission on Children, 1991, p. 287). Despite this inhospitable climate for human service collaboration, a serious, concerted effort must be undertaken to redesign the current fragmented array of human services "programs" to create comprehensive, collaborative, and integrated human service support structures at the community level.

Currently, management responsibility for federal and state human services programs is widely dispersed at the state and local government levels, with multiple service-delivery agencies scattered throughout the community. If children and families are to receive the critical mass of needed services—and communities are to make them available in a coordinated and continuous fashion—there must be collaboration among a variety of public and private agencies and programs and *with* families.

Given the comprehensive focus of CCSSO's November 1992 policy statement—preparation of students "for productive employment, healthful lifestyles,

knowledgeable and contributing citizenship, strong family formation, and other adult responsibilities" (CCSSO, 1993)—important public and nonpublic human service *collaborators* at the local level include the administrative and professional staff of publicly funded, private, and voluntary organizations, as follows (for funding sources, see Appendix A):

1. Health and nutrition agencies, including community health centers and other outpatient health care providers and hospitals.
2. Mental health service providers.
3. Child care providers.
4. Family courts and social services providers, including family support and child welfare agencies.
5. Head Start centers and other providers of early childhood and preschool education services.
6. Elementary and secondary schools.
7. Providers of substance abuse prevention and treatment service, including residential programs.
8. Law enforcement agencies, juvenile courts, and residential detention facilities.

In 1944 and 1945, thousands of "collaborators" were shot and killed throughout Western Europe. Indeed, "consorting with the enemy" is a familiar meaning of the word *collaborate*. The lesson to be drawn from the plight of those collaborating with the Nazis in Western Europe is an important one—it is important that the individuals and families for which the collaboration is occurring have a positive stake in the successful outcome of the collaboration. Thus, a successful education and human service collaboration on behalf of children, particularly those in multiproblem families, must not only be among professionals but also *with* children and families. Without the direct involvement of families, collaboration among professionals too easily becomes doing something *to* or *for* children and families.

## CURRENT STRUCTURES OF SERVICES FOR CHILDREN AND FAMILIES

A review of the day-to-day functioning, child and family outcomes, and economic consequences of the current array of education and human service support programs demonstrates convincingly that, given the parameters of the comprehensive collaborative effort urged by CCSSO (e.g., the measurable outcome goals and the range of potential collaborators), a new comprehensive system of children's and family services and supports must be created to replace the current education and human services structures.

### Day-To-Day Functioning of the Current Array of Categorical Programs

In the United States, human services are currently provided to children and families through a large number of separate, chiefly categorical programs operated by both public and private agencies and funded both publicly and privately (see Appendix A). Over the past three decades, more than 200 of these categorical programs have been created in an effort to intervene directly in the lives of children and families. The current structures of education and human services programs lack both any coherent unified sense of outcome accountability and any real collaboration among human service professionals and with families. Indeed, most "programs" continue to exist, precisely because problems are not solved. Federal discretionary program support is usually predicated upon a showing of unmet need rather than improved performance; and too much outcome success would lead most likely to the allocation of decreased categorical grant resources to an agency and thus to potentially severe punishment of already underpaid service professionals.

*State Programs.* States, mostly mirroring the federal administrative structure, have turned the day-to-day operations of these programs to numerous, different state and local agencies. Each state agency responds first to the demands and requirements of its funding source. This encourages categorical thinking at the local level, preventing the development of successful,comprehensive systems for individuals and families.

In the current human service systems, the principal measure of "success" (and, therefore, of service provider rewards and punishments) has become input (i.e., Has the budget level grown?) rather than output (i.e., How many needs were met or problems solved?). Typically, service providers are accountable to their funding sources for the way they spend their money, not for the outcomes they achieve.

On a day-to-day basis, children and families most frequently encounter an inaccessible, highly uncoordinated array of narrowly focused services and benefits, targeted on different and often conflicting goals, and administered by different agencies, using inconsistent eligibility criteria and conflicting rules, and staffed by overspecialized professionals. Although providers have developed considerable skill in diagnosing and responding to discrete problems, programs rarely respond comprehensively to interre-

lated needs. Many of the services and programs develop their own professional training, certification requirements, and approaches that tend to make the system provider-oriented rather than focused on the individual or family whose needs cross several professional provider communities. Because of overspecialization, children are often served by a categorical program selected on the basis of their most obvious condition or problem and tend to receive only the services that categorical program system offers, regardless of whether such assistance is responsive to their multiple needs (National Commission on Children, 1991, p. 287).

*Federal Programs.* Federal categorical programs are narrowly focused—each has its own specific purpose and target group, rules, informal organizational operating style, and system to identify its consumers. Shaped by the categorical mandates, they inhibit comprehensive approaches to problem solving. Individual programs have generally evolved from legislators' efforts to address individual problems as they have emerged or become matters of public concern. In an effort to target those most in need, each program constrains access to its services to its defined eligible population.

Head Start is an example of this program constraint. Although this program has done an outstanding job of improving child development, it remains principally focused only on four- and five-year-olds. An outcome-oriented strategy with a bias in favor of prevention cannot afford to ignore the years immediately before and after the Head Start experience. For example, during the first three years of life, infants and toddlers have all the needs described earlier—plus, at-risk children in this age group need access to *developmental child care* and a range of integrated family support services, including health and nutrition services (screening, immunization, treatment, and meals), family crisis intervention and preservation, specialized family and individual counseling, and a systematic child abuse and neglect prevention and early intervention protocol (Benoit, 1991; Zigler, 1989, 1991).

Moreover, when the child leaves Head Start and enters school, many of the services integrated within the Head Start program (e.g., EPSDT screening, wraparound child care) are often no longer available. Large numbers of at-risk children in this age group need child care before and after school hours that provides tutoring and other school assistance, mentoring and peer support activities, opportunities for recreation and cultural enrichment, and opportunities to learn about and explore the larger community. In addition, many of these children and their families need to receive support services, including comprehensive health services (including family life programs), mental health services, family crisis intervention and preservation, drug and alcohol prevention, specialized family and individual counseling, delinquency prevention, prevocational training, and dropout prevention (National Commission on Children, 1991, pp. 27-49; Carnegie Council on Adolescent Development, 1989, 1992).

Even during the period of Head Start enrollment, multiproblem families may still need supports not provided by Head Start, including nutritional help (e.g., WIC or Food Stamps), housing subsidies, or parent literacy instruction.

*Barriers to Families.* Families repeatedly report six major types of human service system barriers that stem from the absence of effective collaboration:

1. *"What opportunities are out there?"* Families are provided no assistance in identifying opportunities within the community; and often, individual community agencies simply don't know what services exist within the local environment.
2. *"I don't even know who to call!"* Families are unable to identify and reach anyone in the community who is responsible and readily available to help them identify and gain access to needed services.
3. *"It's not what we needed!"* Services needed by families simply are unavailable within the local community or are ineffective because they are not responsive to the family's individual needs.
4. *"They'll be closed by the time I get there!"* Services or benefits within the community are inaccessible to the family because of service arrangements, such as geographic location and office hours.
5. *"It's the frying pan or the fire!"* Families are discouraged from seeking (or penalized if they obtain) needed services or benefits because of conflicts between the goals and assumptions of different categorical programs.
6. *"We were just left high and dry!"* Services and benefits are prematurely interrupted or terminated, frustrating the attainment of family goals. No one agency or individual is accountable to a particular family for the effective provision of all services that the family needs. Most of these service problems have their origins in the current categorical service construct and the resulting proliferation of numerous categorical programs.

## Negative Child and Family Outcomes

The result of this fragmented approach is that few children and families with multiple problems are able to obtain the needed combination of services and supports. The vast array of federal, state, local, and private sector programs and services for individuals and families makes it particularly difficult for clients with multiple needs to access the services they need. Management responsibility for federal categorical programs is widely dispersed at the state and local government levels, with multiple service delivery agencies scattered throughout the community.

Categorical programs respond best to the specific problems they were created to address. By definition, they are not tailored to respond to the complex and interrelated problems of individuals and families with multiple needs. They are inherently inflexible and respond to specific problems rather than to families, and focus on process rather than on results. Thus, fundamental reliance on a "categorical" program construct (which is a priori circumscribed and exclusionary), rather than a holistic service outcome structure, will inevitably fail to meet the needs of children in families with multiple problems.

For children in families experiencing long-term poverty and economic instability, extremely negative outcomes of the present array of categorical education and human services are well documented (see Appendix B). These negative outcomes include:

- Impaired health as a result of poor prenatal care, undernourishment, and malnutrition.
- High rates of preventable diseases and accidental injury.
- Increased exposure to serious environmental health risks, such as lead poisoning.
- A much greater likelihood of undiagnosed and untreated health problems.
- A significantly increased risk of abuse and neglect, serious mental disorders, and dangerous social behaviors that can lead to serious, long-term problems.
- A much higher rate of academic failure and school dropout (National Commission on Children, 1991; National Center for Children in Poverty, 1990).

Particularly distressing is the fact that three- and four-year-olds from low-income families are actually *less* likely to attend prekindergarten education programs than their more affluent playmates (National Center for Children in Poverty, 1990, p. 73). (See Appendix B for descriptions and statistics concerning children in poverty and associated risks.)

For children in poverty, educational success is particularly at risk because of its causal relationship to health and nutritional problems and child abuse and neglect, factors that often disrupt school attendance and that can severely limit a child's ability to concentrate. In addition, high levels of family stress and social isolation also associated with chronic poverty lessen the likelihood that young children will have early experiences that support optimal intellectual development and "learning readiness," which is the capacity of children to engage actively in the learning process on their first day of school and every day thereafter. Because learning readiness is an ongoing dimension of educational success, it also depends on ongoing encouragement from within the family for older, school-age children as well as active assistance with schoolwork.

## Economic Consequences of Negative Child and Family Outcomes

The failure of the current array of education and human services programs to meet the increasingly complex developmental needs of a rapidly increasing number of children living in families with complex, chronic or interrelated problems also presages serious long-term economic problems for America in three respects. First, the basic economic security of the nation (i.e., at least maintaining the gross domestic product) depends on the ability of business to continue to obtain an adequate supply of skilled, entry-level employees. The availability of entry-level workers (e.g., recent school graduates) will decline sharply over the next 25 years, and the percentage of young adults in the entry-level labor force who are members of a racial/ethnic minority group or from economically disadvantaged families will approximate 50 percent. As a result, employers, who in the past could find substitutes for those children and youth who experienced serious developmental problems, will be increasingly forced to demand a "zero reject" educational system. A serious shortfall of appropriately educated entry-level labor would have serious repercussions for government revenues and standard-of-living consequences for the general population.

Second, the long-term economic self-sufficiency of today's aging baby-boomers will increasingly depend on a high rate of *positive* educational outcomes for at-risk children and youth. If the current dropout rate and level of unemployment among economically disadvantaged youth and young adults were to continue, the financial viability of both the Social Security and Medicare trust funds would be destroyed by the end of the first or second decade of the next century.

Finally, the costs to government in terms of outlays for youth who do not successfully transition from school to either higher education or competitive employment are enormous and growing. Youth who drop out of school are 3.5 times as likely as high school graduates to be arrested and six times as likely to become unmarried parents. In a given year, almost 100,000 children are incarcerated in public and private juvenile justice facilities, and another 55,000 receive mental health care as inpatients in hospitals and residential treatment centers. The average cost of a single year of incarceration in a juvenile detention facility now exceeds $30,000; in an adult prison the average yearly cost exceeds $50,000. For unmarried teenage mothers who do not complete their education, the average length of enrollment on welfare benefits is over 9 years, with a significant portion of the most economically disadvantaged population exceeding 15 years (National Commission on Children, 1991, pp. 32-33, 182; cf., Carnegie Council on Adolescent Development, 1989).

Given these and other, similar outcome trends, the projected "down-stream" financial risk (over the next 20 years) to government, as a de facto insurer of child/youth outcomes, is enormous. The *potentially avoidable* part of that risk (i.e., the avoidable future costs of long-term support) likely to be incurred by unsuccessful "graduates" of today's education and human services structures is well in excess of $12 trillion in current dollars. For example, the average aggregate outlays for teenage mothers and their children who are eligible for AFDC, Medicaid, Food Stamps and special housing subsidies for 9 years exceed $200,000 per family; for 16 years, outlays exceed $350,000. Other potentially avoidable budget outlays for public long-term support include expenditures for income support, nutrition, housing, and health care. It is economically imperative that government act like any other prudent insurer and manage against these potentially avoidable risks in an aggressive fashion.

## Moving to a Comprehensive System of Services for Children and Families

The present structures of education and human services are too narrowly categorical and too inflexible to permit an incremental approach. A major "systems change" will be necessary if services to children in families with multiple and complex needs are to be reformulated on a *critical mass* rather than a *linear* premise. A *linear* approach, which permeates categorical programming, assumes that each categorical program can and, if successful, will make an incremental contribution to meeting the overall needs of a child. A *critical mass* approach is based on a realization that no significant gains of any kind are likely to occur for children living in families with complex needs if a critical mass of services and supports are not available to the entire family. For example, this holistic strategy would assert that no matter how well-designed an instructional program may be, educational success is unlikely for a participating child who is being neglected by a substance-abusing parent whose needs for treatment and rehabilitation services are unidentified and unmet.

In other words, student success is frequently threatened by problems within the child's family, and few important problems threatening a child's success can be successfully addressed without the involvement and support of the child's family. Communities must ensure that problems such as poverty, unemployment, ill health, homelessness, substandard housing, adolescent pregnancy, substance abuse, or delinquency are addressed as *family problems*, rather than as conditions that affect only a child or only a parent (National Commission on Children, 1991, pp. 296-297). Thus, any reform strategy must cut across agencies and disciplines because the failure to address any one of the key factors compromising child outcomes may well undermine totally the efforts made to address all the others. We must develop a comprehensive, integrated system of supports for children and families.

Such a major systems change will also be necessary if services are to become universally available to those who need them, and if service structures that now patronize families are to be responsive to them and enabling of them. Management responsibility for federal categorical programs is widely dispersed at the state and local government levels, with multiple service-delivery agencies scattered throughout the community. No minor alteration of the bureaucratic landscape will lay the groundwork for the transformation of a diffuse and multidisciplinary, categorical array of interventions into a coherent and responsive child and family service system. Moreover, considerations of outcome effectiveness and cost-effectiveness demand that, wherever possible, at-risk families should be helped *before* their problems multiply and become acute, and that both prevention and remediation require a holistic approach that necessarily involves an entirely new collaborative relationship among different agencies, programs, and disciplines.

# CHARACTERISTICS OF A NEW COMPREHENSIVE SERVICE SYSTEM

In designing a comprehensive system of child and family services and supports that will prove effective in meeting the complex needs of children living in multiproblem families, we will find no perfect models or even paradigms. Experience, however, strongly argues that any comprehensive system of child and family services be designed to incorporate each of five basic characteristics:

1. A structure of services integration.
2. A joint-enterprise type of collaboration among professionals and with families.
3. A universal (noncategorical) and neighborhood-based approach to service provision.
4. A holistic, family-centered, and multigenerational service focus.
5. An enabling, responsive, and outcome-accountable management style.

The balance of this article is devoted to a detailed discussion of each of these crucial system characteristics.

## A Structure of Services Integration

From a structural perspective, "services integration" is a system that links together two or more programs or service providers to address an individual's or family's needs in a more coordinated and comprehensive manner. The structural perspective on service integration views structural variables as the durable characteristics that frame basic interactions and approaches to organization. Within this context, the variables of area and function are the competing bases of any organizational structure (Gans & Horton, 1975, p. 32). Several different structural approaches have been used to provide human services to children and families. Figure 2 demonstrates the range of service delivery structures; alternatives from the isolated, programmatic structure which characterizes the *status quo* to total unification of all programs into a single human service structure. The structural approach of "collocation" is a facility-focused strategy to minimize scheduling and transportation barriers within the various collocated services. In contrast to "integration," "collocation" accepts the existing program fragmentation as a feature of a pluralistic system.

A U.S. Department of Health, Education and Welfare Task Force (1972), looking at the issues surrounding services integration more than 20 years ago, identified four aspects of this multiprogram linkage:

1. *Managerial linkages*, including planning, programming, budgeting, evaluation, and training.
2. *Operational linkages*, including outreach, intake, diagnosis, referral, information gathering, tracking, and record keeping.
3. *Organizational linkages*, including common governance and decision-making procedures.
4. *Physical linkages*, including collocation, transportation, and communications.

Three different styles of program linkages have been identified: (a) *voluntary coordination*, where an integrating agency has the dual responsibilities of providing direct services and overseeing the provision of services by other agencies to ensure comprehensiveness; (b) *mediated coordination*, where an integrating agency is primarily responsible for developing linkages among autonomous service providers and provides no direct services itself; and (c) *directed coordination*, where an integrating agency has the authority to mandate linkages among subordinate provider agencies (Gans & Horton, 1975).

**Figure 2**
**Structural Approaches to Service Delivery**

The matrix in Figure 3 shows basic options for structuring a service integration approach. While service integration will not itself eliminate all the shortcomings of the current situation, it is an important precondition for removing both structural and administrative barriers that ultimately frustrate any effort by families to obtain the combination of services and supports they need to solve serious and pervasive economic and social problems.

**Figure 3**
**Options for Structuring Service Integration**

| Area of Linkage | *Voluntary Coordination* | *Mediated Coordination* | *Directed Coordination* |
|---|---|---|---|
| Managerial | | | |
| Operational | | | |
| Organizational | | | |
| Physical | | | |

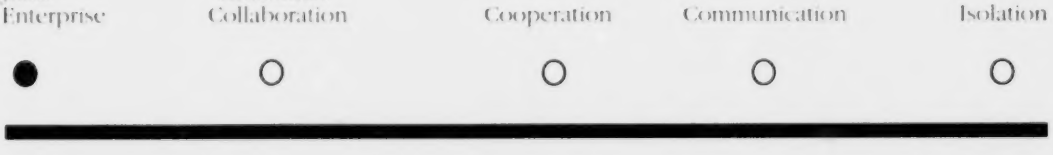
## A Joint-Enterprise Type of Collaboration

A second essential characteristic of a comprehensive child and family support system is the pursuit of joint enterprises among human service professionals and *with* families. The word *collaboration* can be defined in several ways. Figure 4 demonstrates this diversity on a continuum ranging from total isolation to joint enterprise.

The concept of a *joint enterprise* differs from the other more traditional (and less demanding) forms of professional collaboration in one important way. In a joint enterprise, all participating child and family service providers and the family members, themselves, are responsible jointly for the achievement of child-specific and family-specific, unitary, systemic outcome measures. Thus, the success or failure of all of the members of the joint enterprise (including professional and employment rewards and punishments) is based on the collective outcome of teamwork. The difference between traditional collaboration or cooperation, on the one hand, and joint enterprise, on the other, is perhaps best illustrated in industry.

In a traditional collaborative or cooperative approach, while the various workers on an assembly line "cooperate" with each other in the manufacture of an automobile, their success or failure is usually measured by the quality and cost-effectiveness of what they contribute to the car (e.g., door frame, paint, brakes). In a collaborative, joint-enterprise approach, the success or failure of each of the workers on the assembly line would depend entirely on whether the car that they all produce sells. In other words, under a traditional collaboration or cooperation model, the motive for working with other professional team members is to gain help in better accomplishing one's own programmatic objectives; in a collaborative joint-enterprise model, the principal motive is to improve the contribution of all team members to the overall outcome. As a result, each team member becomes much more invested in the contribution to the overall outcome.

**Figure 4**
**Staffing of Service Delivery**



Indeed, the ability of the members of a human services team to assist each other on a continual basis to enhance the overall outcomes is much greater than in most professional fields of endeavor. Despite the elaborate graduate education, credentialing, and licensing systems that have grown in lock-step with the categorical programs that reinforce them, virtually all human service professionals (including teachers) engage in only three basic activities with children: informing, nurturing and protecting. Figure 5 shows the commonality of basic skills among the various human services fields. While the focus of the "informing" may vary (e.g., from academic instruction to personal hygiene to greater self-realization), the actual talents needed to be a successful teacher, pediatrician, social worker, parent, or psychologist are remarkably similar.

However, unlike an automobile assembly line, the human service enterprise is an interactive one. Some professionals, irrespective of graduate degrees or licenses, are simply more effective on certain tasks with certain families. Human chemistry is neither an exact nor a highly predictable science. In a collaborative joint enterprise with a particular child and family, the roles of human service team members should be determined on the basis of a collaborative judgment of which team members are likely to possess the informing, nurturing, or protecting skills, in combination with the positive human chemistry, that will be most effective with the child or family. It is quite conceivable that individual team members would play quite different roles based on the different needs and characteristics of specific children and families.

The joint-enterprise approach also recognizes that collaboration must not only be among professionals but also *with* children and families. Because "personal responsibility" and "family self-sufficiency" are meaningful only when they are accompanied by real choices, a child or family who has neither the opportunity nor choices to act has not had its needs met by the human service system. Thus, the consistent failure of government to provide such opportunities and choices for children and families represents a serious breach of government's most basic obligation. As discussed earlier, families must be an indispensable part of any joint enterprise involving their children.

**Figure 5**
**Three Basic Components of Human Services**

| Dimension | Need | Informing, Nurturing & Protecting |
|---|---|---|
| Development | ■ Safety and shelter | ■ Housing, safeguarding & healing |
| | ■ Food and healthy growth | ■ Nurturing, nutrition & preventive health |
| Autonomy | ■ Relationship/belonging | ■ Loving, nurturing & supporting |
| | ■ Positive self-awareness | ■ Nurturing, enabling, & health promotion |
| | ■ Communication | ■ Modeling, teaching & conversing |
| | ■ Mastery and control | ■ Modeling, teaching & freeing/safeguarding |
| | ■ Socialization and behavior | ■ Modeling, teaching and supporting |
| Maturation | ■ Positive self-concept | ■ Teaching, counseling & ministering |
| | ■ Choice and conduct | ■ Modeling and teaching values & counseling |
| Identity | ■ Bonding and spirituality | ■ Nurturing, caring & supporting |
| | ■ Productivity | ■ Teaching, counseling & healing |
| | ■ Creativity | ■ Inspiring & freeing |
| | ■ Unselfishness and helping | |

## A Universal and Neighborhood-Based Service Approach

One of the most troubling characteristics of the current child and family services structure is the severely restricted eligibility of children and families in need of services. In fact, most current child and family service and cash benefit programs are *categorical* in nature precisely because eligibility for, or entitlement to, benefits or services is determined not only by the need for the benefit or service but also by the presence of a particular extrinsic characteristic, often one that is pejorative at best and disempowering at worst (e.g., economically disadvantaged, handicapped, or emotionally disturbed). In addition to the damaging effects of many categorical eligibility standards on the self-concept of, and system expectations for, these "labeled" children and families who are eligible, large numbers of children and families with severe service needs are currently ineligible. For example, Medicaid eligibility and AFDC income-support eligibility extend to less than 50 percent of children now living in low-income American families, 21 percent of children now living in families with incomes below the poverty level, and 26 percent of children now living in families with incomes between 100 and 150 percent of the poverty level. In addition, minor fluctuations in monthly family income wreak havoc with continuing eligibility in many states and cause serious service discontinuities to occur.

Flexible funding approaches at the local level are also needed to cover services that are crucial to goal achievement but not "covered" (i.e., allowable) under narrow, rigid, categorical service definitions. For example, car repair may be essential to parental employment, and shoes may be essential to ensure school attendance; but neither is likely to be a covered service under most current programs.

## Holistic, Family-Centered and Multigenerational Focus

The current approaches used to attempt to meet the multiple needs of young children and their families appear to be based on the premise that categorical programs can and, if successful, will make an incremental contribution to meeting the overall needs of a child. Experience, on the other hand, repeatedly demonstrates the interconnectedness of child and family problems and the interrelationship of economic and social stresses and problems within the family. As a result, another essential characteristic of a successful child and family service system for children in multiproblem families is the adoption of a *critical mass* service approach that demands both a family-centered and multigenerational focus. As discussed earlier, a critical mass approach assumes that no significant developmental gains of any kind are likely to occur for children living in families with complex needs if a critical mass of services and supports are not available to the entire family.

## Enabling, Responsive, and Outcome-Accountable Management

Experience also demonstrates that not only must service professionals collaborate with families but that *enabling* families to reassert and effectively exercise responsibility for solving their own problems will be a central objective of any truly successful system of child and family services. Indeed, any serious effort to improve the lives and prospects of American children must, in turn, support and strengthen their families (National Commission on Children, 1991, p. 68). This normalization-based strategy requires both that the human and financial resources available within families be expanded, and, in many cases, that family functioning be improved, so that families can take full advantage of a range of social and economic opportunities that are made available. As the Final Report of the National Commission on Children (1991) eloquently put it:

> Society's primary goal must be to support and strengthen families so that children's needs can be met without significant outside intervention. Laws and policies, as well as individual actions, should be aimed at maintaining the authority and integrity of families raising children and offering help and services when needed. But when families are so damaged that their children's health and safety are in danger, society must intervene. Through both individual and collective efforts, society must ensure that children's basic needs for food, clothing, shelter and affection are met when parents are unable to do so alone, and society must protect children who are at serious risk of physical or psychological harm from adults within and outside their families (pp. 71-72).

The Commission also goes on to point out that because they are not self-contained and self-sufficient, families need crucial assistance in the form of jobs, health services, social support, and education from an informal network of community institutions. "Rebuilding a sense of community and reinvigorating [or re-enabling] informal systems of support for families and children" is also a central objective of any comprehensive system reform (National Commission on Children, 1991, pp. 70-71).

An operational style that is, in practice, *responsive* to families and children is a closely related, essential characteristic of a comprehensive system of services and supports for children and their families. Responsiveness of an integrated system to a family has most frequently been the purview of "case management," a process often viewed as the bridge between the

interests of the categorical service providers, on the one hand, and the complex needs of the whole family, on the other (Agranoff & Pattakos, 1979). Five basic activities or functions have long been associated with the role of a case manager: assessment of client need, development of cross-program service plans, arranging for service delivery, service monitoring and assessment, and evaluation and follow-up (Agranoff, 1977).

More recently, case managers in some settings have also been involved both in the outreach and intake process (e.g., EPSDT) and in teaching families self-help skills. Over the past 30 years, at least four different modes of staffing case management have been used:

1. Full-time staffing by an individual worker, usually a generalist.
2. Full-time staffing by an interdisciplinary and usually, interagency, team.
3. The use of different individuals sequentially, at different stages in the service process (e.g., outreach, intake/eligibility, needs assessment).
4. The use of different individuals simultaneously, to "manage" different family needs areas (e.g., child welfare, drug rehabilitation, preventive health care) (Kagan, in press). The matrix in Figure 6 shows basic options for structuring a case management approach along these two *continua*.

If a comprehensive system of child and family services is to be simultaneously enabling and responsive, specially trained *family advocates* (not case managers) must assist each child and family in the planning of services and the selection and assessment of service providers, and in the evaluation of both short-term and long-term service outcomes. (The notion of case "management" conveys the sense of things being done *to* and *for* a "case" rather than with a family. The role of family advocate more properly expresses both the concept of the family as a holistic service unit and the goal of enabling families to help themselves.) Family advocates should be staffed and assigned on a neighborhood basis, with small caseloads (no more than 10 to 20 families), immediate access to multidisciplinary support teams, and flexible control of discretionary funds in the event of a breakdown of collaboration.

Family advocates must be responsible for ensuring that families have ready access to information about applicable service eligibility standards, service options, and potential service providers. Based on such information, and with the "enabling" assistance provided by family advocates, families have direct involvement in, and to the extent possible, *choice and control* over each of the following (the appropriate degree of family empowerment properly balances the desire for family choice and control against government responsibility for the integrity and effectiveness of the programs):

**Figure 6**
**Options For Structuring Case Management**

| | MODE | | | |
|---|---|---|---|---|
| ACTIVITY/ FUNCTION | Full-Time Generalist | Interdisciplinary Team | Multiple Persons -Process Stage | Multiple Persons - Area of Need |
| Outreach & Intake | | | | |
| Needs Assessment | | | | |
| Plan Development | | | | |
| Service Arrangement | | | | |
| Service Monitoring | | | | |
| Self Help Teaching | | | | |
| Evaluation & Followup | | | | |

1. The triggering of needs assessment and service planning, and the setting of service goals and priorities.
2. Decisions regarding service needs and arrangements and the selection of service providers.
3. The environment in which services are provided, and the timing and scheduling of services.
4. The evaluation of service effectiveness (and authorization of payment).

To ensure real outcome accountability, legal, programmatic, and financial responsibility must be explicitly allocated among agencies and across systems; and a single, neighborhood-based professional (the case advocate or another) must be directly accountable to the child and family at all times for both the short-term and long-term outcomes of services and for necessary changes in service design and delivery.

## CONCLUSION

Three central parameters should guide the comprehensive collaborative enterprise envisioned by CCSSO's November 1992 policy statement. A common set of outcome goals must be agreed on, and they must cut across the various disciplines and programmatic structures of educational and human services agencies. The test of the merit of such an effort will be its ability to serve well those children in multiproblem families who fare least well under the present structures. A broad notion of who should collaborate is essential, extending not only to public and nonpublicly employed professionals but to family members themselves.

The evidence is overwhelming that the goals sought by the November 1992 policy statement simply cannot be achieved without a major system reform: a new vision of a comprehensive collaborative system of children's and family services and supports. Key characteristics of that new system must include a structure that truly integrates services through a dynamic family advocacy process; a joint-enterprise type of collaboration that redefines relationships among human services professionals and with families who are seen as collaborators to be enabled, not patronized; a universal approach to "eligibility"; and a holistic, multigenerational focus that sees the needs of the child in the context of the needs of the child's family.

The goal of CCSSO's November 1992 policy statement—joint collaborative action by appropriate state and local agencies to ensure that children and youth are adequately prepared for adult responsibilities—is of vital importance not only to American education but to the very economic and social security of this nation. To accomplish what the CCSSO policy statement envisions will require much more than reform or even a "paradigm shift." What is needed is a true transformation of our present structures to a just and humane system of child and family services and supports. A successful transformation will mean the end of the growing nightmare of serial generations of Americans lost not in battle but to despair and terminal government dependency. Failure will mean the end of the American dream, not only for those now least well off but for the rest of us as well. During such a transformation, no one's turf or sinecure will be safe. Many sacred cows will go dry, and most oxen will be gored.

To try to accomplish this transformation is almost politically unthinkable. As Reinhold Niebuhr (1932, p. 215) points out: "Educators . . . underestimate the conflict of interests in political and economic relations, and attribute to disinterested ignorance what ought usually to be attributed to interested intelligence." That the future lies with our children is a cliche; but like so many others, it is a cliche because it is so unquestionably true. And not to try to accomplish this transformation is morally, socially, and economically unthinkable:

> We live in an age in which personal moral idealism is easily accused of hypocrisy, and frequently deserves it. It is an age in which honesty is possible only when it skirts the edge of cynicism. All this is rather tragic. . . . Yet there is beauty in our tragedy. We can no longer buy the highest satisfactions of the individual life at the expense of social injustice. We cannot build our individual ladders to heaven and leave the total human enterprise unredeemed of its excesses and corruptions (Niebuhr, 1932, p. 277).



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# APPENDIX A

## Funding of Various Human Service Agencies

1. *Health and nutrition agencies:* Primarily those that receive funds from state health agencies under the Preventive Health and Health Services Block Grant and/or The Special Supplemental Food Program for Women, Infants, and Children (WIC). States administer WIC within broad federal requirements and designate local health or welfare agencies for local administration.

   (a) *Community health centers:* Private, nonprofit organizations receive funds from the U.S. Department of Health and Human Services to operate 530 (as of 1991) community health centers (including "family health centers," "community health networks," "neighborhood health centers"). Fees for services vary according to income: Persons with incomes at or below the Federal poverty guidelines pay at most nominal fees, persons with incomes equal to or above 200 percent of the guidelines are charged the full costs of services, and persons with incomes between 100 and 200 percent of the guidelines pay a portion of the costs of services in accordance with a sliding fee schedule.

   (b) *Other outpatient health care providers and hospitals:* Primarily those receiving funds from Medicaid (Title XIX of the Social Security Act), the special Medicaid program for children, Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) and/or the Maternal and Child Health Block Grant, funded under Title V of the Social Security Act.

2. *Mental health service providers:* Primarily those public and nonpublic agencies receiving funds from Medicaid or from state mental health agencies under the Alcohol and Drug Abuse and Mental Health Services Block Grant.

3. *Child care providers:* Primarily those receiving funds under one or more of the following programs that provide financial support for child care and related services for families: (a) the Child Care and Development Block Grant, (b) Child Care for AFDC Recipients, (c) Transitional Child Care, and (d) At-Risk Child Care.

4. *Family courts and social services providers, including family support and child welfare agencies:* Primarily those agencies receiving funds under Titles IV-B and IV-E of the Child Welfare and Adoption Assistance Act, and Title XX of the Social Security Act. Title IV-B is a close-ended formula grant program that provides funds to states for family supports, prevention, and reunification services. Title IV-E of the same act is an open-ended state grant program that provides funds to states for out-of-home placements and referral of troubled families to child welfare agencies. Title XX is the Social Services Block Grant program.

5. *Providers of substance abuse prevention and treatment service, including residential programs:* Primarily those public and nonpublic agencies receiving funds under the Alcohol and Drug Abuse and Mental Health Services Block Grant and/or the program of Demonstration Grants for the Prevention of Alcohol and Other Drug Abuse Among High-Risk Youth.

# APPENDIX B

## Facts About Children in Poverty

The following facts about children in poverty show the complexity of needs and the necessity of a holistic approach:

- Children growing up in poverty are frequently undernourished and inadequately clothed, and live in substandard housing. For them, the world is often a dangerous and threatening place to grow up. It is crime-ridden streets where schools and playgrounds are the domain of gangs and drug dealers, or it is desolate rural areas without adequate roads and running water. It is dilapidated homes with broken windows, poor heating, lead paint, rats, and garbage. It is a world in which children grow up afraid and ashamed of the way they live, where they learn basic survival skills before they learn to read. They experience the most health problems but live in the least healthful environments and have the least access to medical care. They are at the highest risk of academic failure, but often attend the worst schools. Their families experience the most stress but have the fewest social supports (National Commission on Children, 1991, p. 29).

- Poor women are more likely than nonpoor women to deliver low birthweight babies and three times more likely than nonpoor women to obtain prenatal care late in their pregnancies or not at all. Low birthweight is a major determinant of later health and developmental problems (National Center for Children in Poverty, 1990, p. 51).

- Recent estimates of the number of children who experience hunger range from 2 million to 5.5 million. When infants and young children fail to receive adequate nutrition, their growth is often slowed, they are more susceptible to illness, and they are at greater risk of neurodevelopmental problems that impair learning. Studies and surveys show that nutritional problems, most prominently iron deficiency anemia, are frequently associated with poverty and that since 1980 there has been almost no improvement in overcoming iron deficiency among pregnant women and only modest improvement among children. Today, poor children under the age of 6 are more likely than other children to exhibit signs of poor nutrition, such as growth retardation and anemia (National Center for Children in Poverty, 1990, pp. 53, 124).

- In 1979 the Surgeon General of the United States set the goal of immunizing 90 percent of two-year-olds against common childhood diseases by 1990. Yet in 1990 only about 70 percent were immunized against measles, mumps, and rubella. In many inner-cities, only about half of these young children were protected (National Center for Children in Poverty, 1990, pp. 119-120).

- Both fatal and nonfatal accidental injuries occur much more frequently among poor and low-income children than among others (National Center for Children in Poverty, 1990, p. 54).

- An estimated 12 million American children are at risk of lead poisioning (i.e., exposure to 35 to 50 micrograms of lead per deciliter). Recent studies have reported a direct link between lead poisioning and decreased IQ scores and increased likelihood of significant reading disabilities. Other chronic and disabling conditions associated with children living in low-income communities that limit normal childhood activities include HIV infection, respiratory diseases, orthopedic impairments, and sensory impairments. The links between poverty and lead poisioning is so strong that one major research center declared: "as family income decreases, blood lead concentration increases" (National Center for Children in Poverty, 1990, pp. 54, 121).

- Reports of child abuse and neglect rose 259 percent between 1976 and 1989, and more than 50 percent of all out-of-home placements today are for children who need protection from adults in their own homes. Family income is consistently related to all categories of abuse and neglect. Though poverty does not always or automatically lead to child abuse and neglect, it can contribute to stress and a lack of emotional control that can result in violence or an inability to meet a child's basic needs. Indeed, a 1986 national survey reported that rates of abuse in low-income homes were almost five times as high among other children and rates of neglect were nine times as high (National Center for Children in Poverty, 1990, p. 59; National Commission on Children, 1991, p. 284; U.S. Advisory Board on Child Abuse and Neglect, 1990).

- In 1990, over 2.4 million cases of child abuse and neglect were reported in the United States. Estimates of child death due to abuse range from 1,200 to 5,000 deaths, mainly before the age of five. Most of these child abuse and neglect reports concerned repeated and serious physical and/or emotional trauma to young children as the result of seriously inadequate parenting. The educational consequences of such abuse or neglect are numerous, negative and long-term. Traumatized children are hindered in their ability to function in school settings, in terms of cognitive development, inability to relate appropriately to teachers and peers (e.g., either overly hostile or withdrawn) and low self-esteem (National Commission on Child Welfare and Family Preservation, 1991).

- Children begin school "ready to learn" if they are immunized, healthy, well-fed and emotionally secure, if they can socialize with other children and adults, and if they appreciate the importance of learning. While all available evidence strongly indicates that a child's physical and emotional health has direct bearing on his or her ability to realize her full natural potential, as many as 12 percent of children continue to begin school with a significant degree of learning impairment. Preventable

health problems that reduce a child's capacity to learn include prenatal alcohol, tobacco and drug exposure, malnutrition, child abuse and neglect, and lead poisoning.

- An estimated 12-15 percent of American children suffer mental disorders, and the proportion of children seen by a psychologist or psychiatrist for treatment in a given year has risen nearly 80 percent since 1981. Nevertheless, as many as 70 percent of children and adolescents in need of treatment are not receiving services. The most frequent mental disorders experienced by children include symptoms of disruptive behavior (such as attention deficit disorder, hyperactivity, and conduct disorder), and over 5 percent of all school-age children and adolescents suffer from depression and anxiety problems and serious difficulties in learning. Children with attention deficit hyperactivity disorder often have behavioral and conduct problems as well and are particularly vulnerable to substance abuse later. In addition, an estimated 54,472 children currently receive mental health care as inpatients in hospitals and residential treatment centers (National Commission on Children, 1991, pp. 34-35, 284).

- One in four adolescents, approximately 7 million between the ages of 10 and 17, engages in social behaviors that can lead to serious, long-term problems, including premature sexual activity, drug and alcohol use, and delinquent behavior. An estimated 91,646 children currently are detained in public and private juvenile justice facilities. Every year, approximately 1 million teenage girls become pregnant; nearly half of them give birth. Approximately half of these births are to young women who have not yet reached their 18th birthday, and most of them occur outside of marriage. Teenage mothers, especially those who have children before they turn 18, often fail to finish school, and they fare badly in the job market. They are less likely to marry, and when they do, they are more likely to become separated or divorced. For these reasons, they are more likely than girls who delay childbearing to be poor and dependent on welfare. More than half of all young people report that they have tried an illicit drug by the time they complete high school, and rates of crack cocaine use remain disturbingly high among some youths. Young people who abuse drugs are very likely to drop out of school, to engage in premature and unprotected sexual activity, and to commit crimes. They are at very high risk of contracting sexually transmitted diseases, including AIDS, of experiencing accidents and injuries, and of ending up in jail (National Commission on Children, 1991, pp. 34-35, 119-124, 284).

- Poor children are also more likely to be enrolled in troubled schools with limited staff and material resources, and their families are often least likely to have the academic skills and personal resources to compensate for their school's deficiencies. About 30 percent of ninth graders do not graduate from high school four years later, and many fail to return and graduate. Approximately 500,000 young people drop out of school each year. In the nation's large urban centers, attrition rates are even higher: as many as half of all students drop out. These young people will be only marginally literate and virtually unemployable. The consequences of dropping out of school are not solely economic, however. Dropouts are 3.5 times as likely as high school graduates to be arrested, and 6 times as likely to become unmarried parents (National Commission on Children, 1991, pp. 32-33, 182; cf., Carnegie Council on Adolescent Development, 1989).